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DATE: October 5, 2000

TO: Hospitals in Family Care Pilot Counties
Family Care Pilot Resource Centers

FROM: Susan Schroeder, Director
Bureau of Quality Assurance

Mary Rowin, Family Care Project Manager
Center for Delivery Systems Development

SUBJECT: Family Care Pre-Admission Consultation (PAC) Referrals from Hospitals

Current Family Care statutory language requires hospitals to refer people with a long term care need that will last more than 90 days to a Family Care Resource Center for counseling about long term care options and assessment of functional need. Hospitals that do not refer people appropriately may be fined up to $500 for each person who was not referred.

The Family Care Pilot Resource Centers and hospitals that implemented hospital referrals to Resource Centers for Family Care pre-admission consultation (PAC) this summer reported numerous difficulties. Hospitals were unclear as to which patients being discharged needed to be referred to the local Resource Center and because of the potential fines tended to err on the side of referring everyone. Resource Centers thus experienced a very high volume of referrals of people who did not meet the definition of having a long term care need that will last more than 90 days.

Upon review of the process with Resource Centers and hospital staff, the Department determined that simply clarifying who should be referred or eliminating the fines would not be sufficient remedies. Instead, the Department will take two steps to resolve the problems that the PAC referral process has been causing Resource Centers and hospitals.

First, the Department is requesting a change in the current statutes to remove hospitals from the required PAC referral process in the 2001-2003 biennial budget. If this change is made, hospitals will not be required by law to refer patients whom they discharge to the Resource Centers.

Second, per this memo, the Department is delaying the implementation of the current statutory requirement that hospitals must refer people with long term care needs to a Resource Center for

Pre-Admission Consultation. The Department has the authority to delay the implementation of this requirement as it has the authority to phase in PAC referrals, including PAC referrals from hospitals, to the Resource Centers. The Department's decision to delay this requirement means that no hospital will be required to make any PAC referrals to the Resource Centers during the remainder of the current budget biennium. Consequently, the Department will not, for the remainder of the current budget biennium, be monitoring the performance of hospitals to determine whether or not they are referring people with a long term care need to the Resource Centers.

At the same time that the Department is taking the two steps described above, the Department also wants to strongly encourage local Resource Centers and local hospitals to work together to give as many of their citizens with long term care needs as possible the opportunity to learn about the Family Care benefit. Accordingly, we urge hospitals to contact the local Resource Centers and work with them to develop procedures whereby the hospitals can refer, on a voluntary basis, appropriate individuals to the Resource Centers.

In order to suggest answers to the sorts of questions hospitals might well have about working with the Resource Centers, we have attached a model Memorandum of Understanding that the Department has developed based on a "hospital link" agreement used by Waushara County. And in order to suggest answers to the sorts of questions hospitals might well have about deciding when it is appropriate to voluntarily refer an individual being discharged to a Resource Center, we have attached guidelines intended to help hospitals evaluate an individual's need for long term care services. If you have questions about this memo, please contact Alice Mirk at 608-261-8878 or e-mail her at mirka@dhfs.state.wi.us.

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GUIDELINES FOR HOSPITAL REFERRALS TO RESOURCE CENTER

Resource Centers are expected to maintain linkages with local hospitals to ensure that hospital staff (especially discharge planners) and hospital patients can access Resource Center services when appropriate. This guide is intended to help hospital discharge planners understand when to refer and when not to refer to a Resource Center.

Generally, persons likely to benefit from a referral to the Resource Center are

> **adults with a long term care condition expected to last for more than 90 days or result in death within one year, related to physical disability, developmental disability, irreversible dementia (onset any age) or infirmities of aging.**

Resource Center staff have been trained on how to apply the statutory definitions of the "target groups" of infirmities of aging, developmental disabilities, and physical disabilities. Hospital discharge planners need only focus on one fairly straightforward question:

Will this adult have long term care needs <u>beyond--*for more than*--</u> 90 days?

Definition of Long Term Care Needs:

"Long term care (LTC) needs" means assistance required **for more than 90 days** to perform activities of daily living (ADLs; bathing, dressing, eating, mobility, transfers, toileting) or with instrumental activities of daily living (IADLs; managing medications or treatments, money management, meal preparation, use of telephone). It does not matter who provides the assistance. So, even if family assists with ADLs/IADLs for more than 90 days, the person does have LTC needs. If the person is independent with these tasks, s/he does not have LTC needs.

I. DO REFER PEOPLE who <u>are</u> expected to have long term care needs <u>beyond</u>-- for more than-- 90 days. These include the following:

I A. People who were independent before this episode but who are expected to have LTC needs beyond 90 days from discharge.

Example 1: 72 year old male status post recent left CVA being discharged to rehabilitation facility. He has hemiplegia and near-total aphasia. He was independent in all ADLs/IADLs before the CVA, but is expected to have LTC needs for more than 90 days from now. Refer.

I B. People who needed help with ADLs/ IADLs before current episode who are expected to need that help (or more) <u>beyond</u> 90 days.

Example 1: 84 year old woman status post successful hip replacement after fracture six days ago. This woman is very frail and has needed assistance with bathing, dressing, transfers, and mobility for several years. She is now being transferred to a nursing home for Medicare-covered rehab. It is expected that even if she recovers well from this episode, she will still require assistance to

perform ADLs and IADLs; in other words, she is expected to have LTC needs beyond 90 days. Refer.

Example 2: 33 year old woman with developmental disabilities including moderate mental retardation being discharged to her parents' home after appendectomy. She is expected to recover fully. Her parents have performed all of her cares including many ADLs and all IADLs, all her life, and will resume doing so. They have never received any help from any public programs. Refer.

Notice that the only question is whether the person is expected to have LTC needs beyond – for more than – 90 days. It does not matter whether or not s/he will receive, e.g., Medicare-funded nursing home stay for "rehabilitation": It only matters whether or not s/he will need any help beyond 90 days.

Also, the question is whether the person "is expected" to have LTC needs. Health care professionals routinely make such predictions based on the person's current status and expected course of treatment and recovery. If unexpected problems occur later, a PAC referral could be made (by any facility) whenever it becomes evident that the person will have LTC needs beyond 90 days from then.

II. DO NOT REFER people who are not expected to have long term care needs beyond - for more than - 90 days. These include the following:

II A. People whose death is imminent.

Such persons do not have LTC needs expected to last beyond 90 days (and it is the hospital's responsibility to address the person's and family's immediate needs).

Resource Center staff must follow up with phone calls and it is extremely discomforting for families to receive such calls after the person just died.

II B. People expected to be independent in ADLs and IADLs 90 days from now.

This includes people who were independent in ADLs and IADLs before current episode and who are expected to regain independence. (This can include people with disabilities or medical diagnoses; the criterion is independent functioning.)

Example 1: Active, healthy 84 year old woman status post successful hip replacement six days ago after fracture. Before her accident, she was independent in all ADLs and IADLs. She will go to a nursing home for a few weeks of Medicare-covered rehab. She is expected to heal well and to resume independence in her ADLs and IADLs; in other words, she is not expected to have LTC needs for more than 90 days from now. No referral for LTC options counseling is necessary.

Example 2: Active, healthy 68 year old woman being discharged to home after surgery for carpal tunnel syndrome. She was formerly independent in all ADLs and IADLs. She will need assistance with a few things for the next few days and weeks, but is expected to recover to full independence within 30 to 60 days.

Example 3: 34 year old male being discharged to home after inguinal hernia repair with complications. He has diagnosis of cerebral palsy but it is mild and does not interfere with his ADLs or IADLs, all of which he performs independently, along with working full time. He has no long term care needs.

3. Other Exemptions:

Do not refer people who meet any of the following criteria:

- The person is under the age of 17 years and 9 months.
- The person is already an enrollee of a Family Care Care Management Organization (CMO).
- The person is already on a home and community based waiver program such as "COP" (Community Options Program) or "CIP" (Community Integration Program).
- The person has had a WI LTC Functional Screen completed within the previous 6 months.

We realize that hospital staff usually have no way of knowing whether a LTC Functional screen was completed with an individual, or even whether the person is on CIP or COP. Sometimes consumers themselves are unclear. But it would reduce unnecessary work for the Resource Center if hospital staff at least ask the consumer and/or family before making the referral.

4. Other points:

Most Resource Centers prefer hospital PAC referrals to occur within a few days of discharge, not sooner. Otherwise, Resource Centers have to make numerous phone calls to locate the person. This (and other points) can be decided locally between each Resource Center and hospital.

MEMORANDUM OF UNDERSTANDING

BETWEEN
_____ RESOURCE CENTER
AND
_____ HOSPITAL

The Hospital agrees that, to achieve the goals of this program, the following elements are best provided by the hospital. The hospital intends to:

1. Identify and target _____ County Residents who are admitted to the hospital who are sixty-five years of age or older and who have current or potential long-term care needs. Ideally this would be done within twenty-four hours of admission. It will be the hospital's responsibility to develop a plan that is workable within the hospital's system to accomplish this task. This plan will be put in writing and its effectiveness reviewed quarterly and shared with the Quality Improvement Team at the Resource Center.

2. Provide the potentially eligible patient or his/her family with a Resource Center Packet which will include the _____ RC Brochure, and general information about potential benefits and resources available for long term care in the community. The hospital will develop a workable system to ensure that interested patients are referred.

3. Refer to the Resource Center patients who are willing to discuss Long Term Care options. The referral information and process will be decided upon mutually by the hospital and resource center.

4. Identify that the social work department from the hospital, will be responsible for the referred patient and will:

    a. ensure the availability of patient records to Resource Center staff so that needs can be identified.
    b. assist in the development of the community case plan,
    c. jointly arrange for identified services,
    d. ensure needed physician orders are secured as well as a Physician's Plan of Care (PPOC) as needed.

5. Identify one individual from the hospital to serve as Resource Center liaison to serve on the Resource Center Quality Improvement Team and to coordinate inter-agency efforts to ensure the success of the process. This individual or their proxy will need to be available for a brief weekly telephone contact with Resource Center staff.

6. Comply with an agreed upon tracking system to monitor _____ County residents sixty-five years or older and people with disabilities from admission to discharge.

7. Communicate with the Resource Center staff on a monthly basis to ensure that the provisions of this agreement are feasible and acceptable for all parties concerned and that alterations to this agreement will be negotiated and clarified when necessary.

The _____ Resource Center agrees that, to achieve the goals of this program, the following elements are best provided by the Resource Center. The Resource Center agrees to:

1. Provide training to hospital staff to outline the range and purpose of the Resource Center. This training will include an in-depth discussion of processes used by the Resource Center to access a variety of services. Resource Center staff will be available on an ongoing basis as a resource to hospital staff.

    a. Respond to the request for Options Counseling within three working days of the referral and perform the functional screen as required and requested by the patient to identify the applicant's eligibility for long term care programs.

2. Identify one individual who will be responsible for each patient referred. This individual will work with the hospital staff in the development of a discharge plan and the arrangement for immediate services upon discharge as necessary. S/he will also be responsible for paperwork required for access to long term care programs.

3. The Resource Center worker will update the discharge planner within a month of discharge to relate current circumstances and to review the discharge experience.

4. Provide follow-up for individuals who have been discharged to the nursing homes for rehabilitation stays and will work on access and eligibility for community care with the nursing home social worker and other care provider agencies.

5. Initiate a weekly contact with the participating hospitals to monitor the Resource Center process, provide patient updates, and discuss potential referrals.

6. Develop a system of extended availability of staff to respond to emergency functional eligibility assessments and to be a resource for hospital staff.

7. Gather, compile and analyze data relevant to the Resource Center process and report on the successes and challenges identified by the data.

8. Conduct a client satisfaction survey for all identified _____ County residents sixty-five and over and people with disabilities who have been involved in this process within a month of discharge to ascertain strengths and weakness of the program.

9. Work with the hospital on an ongoing basis to ensure the provisions of this agreement are feasible and acceptable for all parties concerned and that alterations to this agreement will be negotiated and clarified when necessary.